National Virus Reference Laboratory
University College Dublin
Belfield, Dublin 4

Tel General Enquiries: 01 716 4401
Web: nvrl.ucd.ie
Email: nvrl@ucd.ie

STI INVESTIGATION REQUEST FORM

PATIENT DETAILS

Forename:

Surname:

Address (Mandatory):

DOB: D D M M Y Y Y Y

Sex : F M

Hospital Number (Mandatory if available)

Laboratory Number (Mandatory if available)

SPECIMEN DETAILS

Specimen Type(s): Serum | Plasma | Other:

Specimen Date & Time of collection: D D M M Y Y Y Y / H H M M

Collection Details

Sample collected by

Signature

CLINICAL DETAILS

Clinical details aid the selection of an optimal testing strategy.

Date of onset of symptoms: D D M M Y Y Y Y

Clinical Details:

Swab site(s):

HVS ☐ **Throat** ☐

LVS ☐ **Rectal** ☐

ECS ☐ **Other** ___________________

INVESTIGATION REQUIRED (For sample collection requirements please refer to the NVRL User Manual (nvrl.ucd.ie))

Viral Serology Investigations

HIV .... ☐

HBsAg .... ☐

anti-Hbcore .... ☐

anti-HBs .... ☐

Hepatitis C .... ☐

Syphilis .... ☐

Other (please specify) ________________________

Molecular Investigations **Specimen type:**

Chlamydia trachomatis and Neisseria gonnorhoeae ☐ **APTIMA**

Trichomonas Vaginalis .... ☐ **APTIMA**

Mycoplasma Genitalium .... ☐ **APTIMA**

Herpes Simplex Virus .... ☐ **Viral swab**

Electron Microscopy

Molluscum contagiosum (scrapings/vesicle fluid only) ☐

DOCTOR / SURGERY DETAILS/REQUESTING HOSPITAL DETAILS

Name:

Signature:

IMC No:

Date: D D M M Y Y Y Y

Tel:

Surgery Address / Hospital Address/Stamp

N.B. Please note that the sample will not be processed without address of surgery or hospital